

**John A. Pfeiffer, M.D,  
Family Practice – Celebration**

660 Celebration Ave., Suite 180  
Celebration, FL 34747-4926

phone : 407-566-1600  
fax : 407-566-1604

**Patient Registration Form**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Nickname \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt.# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Fax \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Sex \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_  
Emergency contact name \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Insurance**

Insurance Name \_\_\_\_\_  
Insurance Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Policy Holders Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**Secondary Insurance**

Insurance Name \_\_\_\_\_  
Insurance Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Policy Holders Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

I hereby authorize payment directly to John A. Pfeiffer, M.D. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

**Signature of Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_